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FISCAL IMPACT STATEMENT

LS 7142 **NOTE PREPARED:** Feb 6, 2013
BILL NUMBER: HB 1428 **BILL AMENDED:**

SUBJECT: Home and Community-Based Services and Brain Injury Services.

FIRST AUTHOR: Rep. Saunders **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
X **DEDICATED**
X **FEDERAL**

Summary of Legislation: This bill has the following provisions:

(1) Establishes the Division of Brain Injury and Cognitive Rehabilitative Services (BICRS) within the Office of the Secretary of Family and Social Services Administration (FSSA) and sets forth BICRS's duties.
(2) Establishes the Office of Client Rights and Protections (CRF) within BICRS.
(3) Establishes the Program and Policy Review Advisory Committee.
(4) Requires Medicaid to include traumatic brain injury services.
(5) Requires the Office of Medicaid Policy and Planning (OMPP) to apply to the United States Department of Health and Human Services for a Medicaid waiver to provide brain injury services to individuals with traumatic brain injuries and other acquired brain injuries.
(6) Requires the Division of Aging (DOA) to meet specified requirements in the distribution of funds for the Community and Home Options to Institutional Care for the Elderly and Disabled Program (CHOICE) to Area Agencies on Aging (AAAs).
(7) Specifies that funds that are appropriated to CHOICE:
    (A) may not be used as a match for Medicaid waiver services or for any other purpose; and
    (B) may not revert to the General Fund.
(8) Specifies funds available for Home and Community-Based Long-Term Care Services (HCBS).
(9) Requires the DOA to provide HCBS statewide and specifies that the services available must include the services included in the program on January 1, 2013.
(10) Specifies that an individual who is eligible for HCBS must receive services specified in a care plan that has been agreed to by the individual unless the individual specifies in writing that the individual would like to receive care in a nursing facility or institutional setting.

(11) Requires FSSA to eliminate the waiting list of eligible individuals seeking HCBS and requires an individual who was on the waiting list on July 1, 2013, to begin receiving HCBS by July 1, 2014.
(12) Requires an eligible individual to receive HCBS services within 29 days after a determination of eligibility.
(13) Allows an AAA to make the initial eligibility determination for specified programs.
(14) Specifies conditions that must be met before an individual may be transitioned from HCBS to a nursing facility or institutional care.
(15) Requires caregiver support in specified circumstances.
(16) Requires the DOA to establish:

(1) an independent provider of home and community-based services training and certification program;
(2) a statewide registry of independent HCBS providers;
(3) fiscal intermediary services to assist self-directed care individuals; and
(4) a self-directed care telephone hotline.

Effective Date: Upon passage; July 1, 2013.

Explanation of State Expenditures: *Summary:* The fiscal impact of this bill is indeterminate being dependent upon future administrative and legislative actions.. The bill requires the establishment of a new Division within FSSA to provide services to a population defined as diagnosed with TBI and ABI. The number of individuals eligible to receive these services is not known at this time. At a minimum, the bill requires the appointment of a division director and a deputy director. Approximately $239,000 is estimated to be needed to provide for salary and benefits for these two positions. These expenses should qualify for Medicaid administrative matching funds of 50%.

The bill would prohibit the transfer of state money from the CHOICE appropriation. If the CHOICE appropriation is left at the current level, disallowing the transfer ($18 M for FY 2013) would require additional funds in the Medicaid budget to pay the state share for the Medicaid Aged and Disabled Waiver. The language in the bill mirrors provisions available to state Medicaid programs under the Patient Protection and Affordable Care Act (ACA), but the bill does not authorize FSSA to seek the State Plan amendments that might be used to implement the provisions of the bill.

The bill further requires the provision of specified services to certain individuals and requires they be available upon passage. It is unclear when the required services that Medicaid and CHOICE clients must be provided are to be available or when required actions must be undertaken. The bill requires the elimination of waiting lists for the home and community-based services waivers and the CHOICE program. Based on information from June 2012, this provision is estimated to cost $332.1 M in state funds. The need for additional funds would be mitigated by an unknown level of savings to be achieved by preventing persons currently on the HCBS waiver and CHOICE waiting lists from entering nursing facilities or other institutional settings. The effective date of the majority of provisions in the bill is upon passage.

Other provisions of the bill would require information technology upgrades and additional staff within FSSA.

The bill also creates two new advisory committees requiring salary per diem and travel expenses to be paid to specified members of the committees. It is uncertain when services to which Medicaid clients would be entitled must be provided or when required actions must be undertaken.

The effective date of the bill is upon passage, yet the bill also requires a planning and reporting process for the implementation and funding of the TBI/ABI services required in the bill.

[An information request with the FSSA is pending regarding the impact of this bill on the Division of Aging, and information will be provided as it becomes available.]

Additional Information:

Establishment of the Division of Brain Injury and Cognitive Rehabilitative Services (DBICRS): The bill requires the establishment of a new division within FSSA requiring the appointment of a director and a deputy director to oversee the Office of Client Rights and Protections, which is established within the DBICRS. Assuming these positions would be filled at approximately the same salary levels as existing FSSA division directors and deputies, a total of about $239,000 would be necessary to fill these required positions. This estimate does not include other personal services expenses or other operating expenses that would be associated with new positions and responsibilities.

The bill also allows the director to hire personnel necessary to perform the DBICRS's work with the approval of the State Budget Agency (SBA).The bill does not include an appropriation. However, as an indicator of the funding the DBICRS may require, the Division of Aging, one of the smaller FSSA divisions, currently employs 31 persons with total salary and benefits expenses of approximately $2.2 M. (This estimate does not include other operating expenses.) Some existing positions may be transferred along with the associated duties from other divisions since the DBICRS will take over responsibility for the TBI waiver and for individuals who may be receiving home and community-based services from other waiver programs. (Stroke patients on the Aged and Disabled Waiver and waiting list as well as others would be eligible to receive services under the program defined in the bill.) The administrative expenses of the DBICRS appear to be eligible for federal Medicaid administrative match of 50%. Ultimately, the cost of the new DBICRS will be determined by appropriations made by the General Assembly.

Program and Policy Review Advisory Committee: The bill establishes the 14-member Program and Policy Review Advisory Committee to advise the Secretary of FSSA on the policies, programs and funding required to implement the TBI/ABI related provisions of the bill. The Committee consists of 4 specified state employees, 4 specified members of the General Assembly, and 6 consumers to be appointed by the Governor no later than July 1, 2013. The bill specifies the Committee is to meet four times annually. Consumer members are entitled to minimum salary per diem and travel expenses. As of January 1, 2013, mileage reimbursement is $0.55 per mile and the minimum salary per diem is $50. The advisory committee will require $1,200 annually for salary per diem for the 6 appointed consumer members; travel expenses would depend on the home location of the appointees and the location of the meetings. The bill is silent with regard to per diem and expense reimbursement for the legislative members.

Establishment of the Office of Client Rights and Protections: The Office of Client Rights and Protections is established within the DBICRS to review any program or policy established by the DBICRS for the impact on the civil and human rights of individuals receiving brain injury services. The Deputy Director overseeing the Office is required to appoint at least seven individuals to an advisory committee that is established to advise the Office on matters affecting the civil and human rights of individuals receiving brain injury services. The advisory committee is required to meet four times annually, and members are entitled to minimum salary per diem and travel expenses. As of January 1, 2013, mileage reimbursement is $0.55 per mile and the minimum salary per diem is $50. If the minimum seven members are appointed, the advisory committee will require $1,400 annually for salary per diem; travel expenses would depend on the home location of the appointees and the location of the meetings. The duties of the Office appear to be similar to that of an ombudsman. If that is

the assumption, then the deputy director position should be sufficient to carry out the functions of the Office if support staff is available from the DBICRS. [See *Establishment of the DBICRS* above.]

Establishment of the Brain Injury and Cognitive Rehabilitative Services Statewide Network: The DBICRS is required to establish a statewide network of brain injury and cognitive rehabilitation services for residents, including trauma care, acute care, post-acute care, and rehabilitative services. The bill requires that these services must be available to any resident qualifying for services under the bill.

Establishment of the Brain Injury and Cognitive Rehabilitative Services Program: The bill defines the terms "traumatic brain injury" (TBI) and "acquired brain injury" (ABI) and defines brain injury services, which include home and community-based services. The bill requires the DBICRS to fund the services, although it does not contain an appropriation. The bill further provides that the Secretary of FSSA and the Director of the DBICRS are to provide to the General Assembly and the Governor, a plan to implement and fund the requirements of the bill, Medicaid State Plan services for brain injury services, and a Medicaid waiver for TBI and ABI. The bill does not specify what services the waiver is to cover. It does specify that the financial eligibility standard is required to be not more than 300% of the SSI income level (the same standard as other existing home and community-based services waivers). The fiscal impact of the provisions regarding the required services to be available under the bill is indeterminate. The bill is effective upon passage and requires provision of the services to all described eligible persons. It includes the defined brain injury services as Medicaid state plan services, and it requires the DBICRS to apply for a waiver for TBI/ABI while also providing for the development of a plan to accomplish and fund these very actions.

The bill as written would establish a program to provide the defined brain injury services, including home and community-based services typically provided under waivers, to all Medicaid-eligible clients diagnosed with TBI or ABI. The new State Plan services would be available statewide to any Medicaid-eligible client with the required diagnosis, as well as to existing home and community-based services waiver clients with a diagnosis of TBI or ABI - potentially opening waiver slots for clients currently served under other waivers. State Plan services would also be available to TBI/ABI diagnosed individuals meeting the waiver financial eligibility standards of 300% of SSI who may or may not be on an existing waiver waiting list. In other words, individuals with TBI/SBI who meet level-of-care requirements and have an income below 300% SSI would qualify to receive the defined State Plan brain injury services immediately, even though they may be on a waiting list to receive waiver services. The number of individuals eligible to receive these services is not known at this time.

Required Provision of Home and Community-Based Services: the bill also requires that any person meeting the income and level-of-care eligibility standards for the CHOICE program or for any Medicaid waiver must receive HCBS unless the individual requests institutional care in writing. This provision does not include any allowance for efficiency or budget neutrality that is required for services provided under the Medicaid waivers. Any person requiring any level of service would be required to be cared for in their home regardless of the cost unless the individual or representative signs an affidavit requesting institutional services. The bill further provides that the services provided to the individual must be included in a health care plan that provides sufficient services and hours of services to allow the individual to remain independent and safe. The plan is required to be approved by the individual. (The bill does not provide for a representative's approval.)

The bill requires the level of services offered under the current HCBS program may not be reduced - services that were provided on January 1, 2013, must be provided in addition to all services required by the bill. It also specifies that caregiver support services must be available for any person receiving publicly funded HCBS.

The bill requires that all waiting lists for CHOICE and Medicaid waiver services must be eliminated before July 1, 2014. Additionally, eligible individuals must receive services within 30 days. This will require care plans be executed and approved by the eligible individuals. It is not known at this time if the AAAs and the DoA have sufficient staff to meet these requirements.

The language in the bill mirrors provisions open to state Medicaid programs under the Patient Protection and Affordable Care Act (ACA) concerning Removal of Barriers to HCBS and the Community First Choice Option. Under the Removal of Barriers option, states may provide more types of HCBS under a state plan amendment to individuals with higher levels of need rather than through a waiver. The Community First Choice option allows states to offer HCBS attendant services and supports to assist with activities of daily living. The Community First Choice option is eligible for an enhanced federal match of 6% for reimbursable expenditures under the program. The bill does not authorize FSSA to apply for or submit State Plan amendments to implement the provisions of the bill. The provisions requiring services to be available would be effective upon passage.

Elimination of Waiting Lists: For June 2012, FSSA reported the CHOICE and Medicaid waiver waiting lists and average monthly costs as shown below.

Waiver	Clients	Monthly Cost	Total Cost	State Funds
Aged and Disabled (A&D)	3,273	$3,320	$ 130.4 M	$ 43.0 M
Traumatic Brain Injury	109	$4,765	$ 6.2 M	$ 2.1 M
DD, Autism & SS*	13,400	$4,388	$ 705.6 M	$ 232.8M
Total Waiver	**16,782**		**$ 842.2 M**	**$ 277.9 M**
CHOICE	6,024	$756	$ 54.6 M	$ 54.2 M
Total CHOICE and Waiver	**22,806**		**$ 896.8 M**	**$ 332.1 M**

* These waivers have since been renewed as the Community Integration and Habilitation (CIH)Waiver and the Family Supports waiver.

The actual impact on state expenditures of eliminating the waiting lists in the CHOICE program and for the Medicaid waivers would be subject to an unknown level of savings that might be achieved through actions taken by the General Assembly or by eliminating institutional services.

The bill requires the DoA to make self-directed care available statewide to any recipient demonstrating the ability to self-direct their care in coordination with plans prepared by a local AAA and as approved by the recipient or representative. The bill requires the DoA to use the AAAs to locally implement self-directed home health care. Presumably, this would be done by issuing vouchers for a predetermined level of need.

HCBS Provider Training/ Certification/ Registry and Other Services: These provisions appear to require the Division on Aging to coordinate services statewide for individual providers and consumers of self-directed care. The cost of the required services is not known at this time. However, in the past, FSSA has indicated that information system upgrades and additional staffing would be necessary to implement these types of requirements.

Prohibition of Transfers or Reversions: The bill would prohibit the transfer of any amount of CHOICE

appropriations to the Medicaid budget to provide the state share of funding for the Aged and Disabled Home- and Community-Based Services Waiver. This transfer has been specifically provided for in previous years' noncode budget bills. The current budget specifies that no more than $18 M may be transferred from the CHOICE appropriation in FY 2013. If the CHOICE appropriation is left at the current level, disallowing the transfer would require additional funds in the Medicaid budget to pay the state share for the Medicaid Aged and Disabled Waiver. The $18 M transfer of CHOICE funds to the Medicaid waiver leverages an additional $36.5 M in federal matching funds for total HCBS expenditures of approximately $54.5 M. However, if the General Assembly was to choose to reduce the CHOICE appropriation to reflect the amounts previously remaining after the recommended transfer and appropriate the funds available for transfer directly to the Medicaid program, this provision would have a neutral fiscal impact.

The bill also specifies the source of funds for the HCBS program, including the state funds appropriated for the CHOICE program and allocated for Medicaid, and specifies that funds that were allocated for institutional care saved by the state due to the diversion of an eligible individual to HCBS are included. The savings are required to be used for HCBS services in the CHOICE program, Medicaid, or a Medicaid waiver. This provision appears to allow transfers of open-ended Medicaid funds to the CHOICE program while other provisions mentioned above would prohibit transfers from the CHOICE program. The provision requires the calculation of savings on an individual basis with the savings based on actions that did not occur, using costs that were never incurred.

Distribution of Funds: The bill requires the DoA to distribute funds to the AAAs so that funds are available for client services and that allow the AAAs to manage funds consistent with the AAA's caseload. The fiscal impact of this requirement is indeterminate. The DoA operates the CHOICE program using contracts to distribute the available funds among the 16 AAAs.

Presumptive Eligibility (PE): The bill would allow the Area Agencies on Aging to make a determination that an applicant who is at risk of being institutionalized if immediate long-term care services are not received is presumptively eligible for Medicaid waiver services if a Medicaid application has been completed and the AAA has determined the applicant is deficient in at least three activities of daily living. The AAA's determination of presumptive eligibility would allow for the immediate provision of the allowable services needed by the applicant. The bill provides that the AAAs would have the flexibility to determine how services would be funded until such time as the applicant is determined to be eligible for the Medicaid waiver. This provision of the bill will apply to all HCBS waivers administered by DoA. It is unclear if the AAAs have sufficient resources to perform this function.

The cost of this provision is associated with the number of waiver slots available; if there are no waiver slots available there should be no expenses incurred. This would also eliminate any potential for Medicaid savings from the diversion of individuals from more expensive nursing facility placements. Cost is also associated with the number of persons that might be determined to be presumptively eligible, the point in time that federal reimbursement would become available for waiver recipients (FSSA reports that federal matching funds are not available for waiver services until a care plan is approved), the expense of services provided to persons subsequently found to be ineligible for Medicaid, and the associated state administrative expense. Presumably, any services provided that are not eligible for Medicaid reimbursement would be funded by the state appropriation for CHOICE or other state and federally funded programs operated by the AAAs.

FSSA has reported in the past that Medicaid information technology system requirements and training expenses to implement a presumptive eligibility option would require $1.2 M. This estimate is based on the cost of

implementing PE for pregnant women. The AAAs are not mandated to make PE determinations by the bill. The level of resources required for the AAAs to perform the PE is not known at this time. If additional resources would be needed to expedite the process, FSSA does not have resources to provide additional funding for the AAA contracts without cutting some other existing service.

Background Information:

CHOICE eligibility standards include the following: (1) 60 years of age or disabled; (2) no income restrictions - cost share is required for anyone above 150% of FPL; (3) assets under $0.5 M; (4) unable to perform two or more assessed activities of daily living (ADL).

Medicaid waiver eligibility standards include the following: (1) 65 years of age or disabled; (2) income level must be at or under 300% of the SSI standard; (3) assets under $1,500 for singles and $2,000 for a couple; (4) unable to perform three or more ADLs.

Presumptive Eligibility: Regarding presumptive eligibility, federal Medicaid matching funds are available for services provided during a period of presumptive eligibility for home and community-based services that are State Plan services - but not for waiver services. For example, Indiana has PE for State Plan services for pregnant women. If a woman receives pregnancy-related services during a PE period and is later determined to be ineligible for Medicaid, the federal matching rate is still available to reimburse for those services. Because the home and community-based services provided under the A&D waiver are not State Plan services, any services provided during a PE period for a person who is found to be ineligible for Medicaid would not be eligible for reimbursement under the Medicaid program. Those expenses would need to be reimbursed using all state dollars or recovered from the applicant.

1915(i) State Plan Amendment: A Section 1915(i) State Plan amendment would allow Medicaid-eligible recipients with a diagnosed traumatic brain injury or acquired brain injury and with incomes less than 150% of the federal poverty level (FPL) to receive a defined set of services, including home and community-based services. [This new option, available under the Deficit Reduction Act of 2005 and expanded by the Affordable Care Act (ACA), allows the state to define a group that does not have to meet the institutional level of care (LOC) required for Medicaid waiver participants.] Under the State Plan option, these services may be supplied to a targeted group such as TBI/ABI on a less stringent basis than those available under a waiver where the number of slots available may be limited. The bill would also allow persons meeting the LOC requirements and financial eligibility requirements for TBI waiver services (income under 300% SSI), to qualify for the defined State Plan services as well. Under the 1915(i) state plan option, a state must estimate the number of persons that are projected to access the services each year. Unlike waiver requirements, states may, if participants exceed the projections, revise the eligibility level of need that future participants must meet in order to qualify for the services with 60 days notice. States may not limit services under the 1915(i) option by maintaining a waiting list, as is possible with a waiver.

Medicaid is jointly funded by the state and federal governments. The effective state share of Medicaid program expenditures is approximately 33% for most services. Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 67%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: *HCBS Provider Training/ Certification/ Registry and Other Services:* The

bill contains no provisions to allow for fees to offset the costs of conducting a training program or for certification.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA.

Local Agencies Affected:

Information Sources: State Staffing Table; FSSA Quarterly Financial Review for DoA and DDARS,June 2012; Social Security Act Section 1915 at http://www.ssa.gov/OP_Home/ssact/title19/1915.htm; http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html; *Federal Funds Information of States Issue Brief 12-36*, September 26, 2012; FSSA *CHOICE Annual Report for FY 2012.*

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